

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07240

7277

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH o. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air R.D.</b>				c. LENGTH OF STAY IN 1b <b>1 month</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harford Convalescent Home</b>				d. STREET ADDRESS <b>Army Chemical Center</b>			
3. NAME OF DECEASED (Type or print) First <b>Sadie</b> Middle <b>Taylor</b> Last <b>Aarnes</b>				4. DATE OF DEATH <b>July</b> Month <b>18</b> Day <b>19</b> Year <b>1956</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>31 Jan 1886</b>		9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Mobile, Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel S. Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Callahan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Col William J. Allen, JR.</b>		Address <b>Army Chemical Center, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic CV Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma L. Breast</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 51. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/23</b> , 19 <b>56</b> , to <b>7/17</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>July 18</b> , 19 <b>56</b> , and that death occurred at <b>4:50</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Bel Air, Md.</b> DATE SIGNED <b>Gerald E Palmer</b>							
ACTUAL SIGNATURE <b>Gerald E Palmer</b> M.D.				PHYSICIAN'S NAME (Type) <b>Gerald E Palmer-MD Bel Air, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>July 19, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Roche Funeral Home</b>		22d. LOCATION (City, town, or county) (State) <b>Mobile, Mobile Co., Alabama</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. McGomes &amp; Son</b> ADDRESS <b>Abingdon Maryland.</b>				24a. REC'D BY REGISTRAR <b>7-21-56</b>		24b. REGISTRAR'S SIGNATURE <b>Rivilla Luvvord</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		M		35		12-1-29		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
Clerical		High School		Married		Catholic		White		White		Brown		Blue	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
4-4-68		JAIL		BALTIMORE		MARYLAND		UNITED STATES		Suicide		Natural		12345	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
DATE OF REGISTRATION		PLACE OF REGISTRATION		CITY		STATE		COUNTRY		REGISTRATION NO.		REGISTRATION NO.		REGISTRATION NO.	
4-10-68		BALTIMORE		MARYLAND		UNITED STATES				12345		12345		12345	

BUREAU V. S.

JUL 24 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07241

7265 **CERTIFICATE OF DEATH**

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>HARFORD</i> MARYLAND		LENGTH OF STAY (in this place) <i>22 days</i>		STATE <i>Md</i> COUNTY <i>HARFORD</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>	
CITY OR TOWN <i>Harre-de-Grace</i>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Harford Memorial Hospital</i>		CITY OR TOWN <i>Aberdeen</i>		STREET ADDRESS (If rural give location) <i>106 LAW ST.</i>	
<b>3. NAME OF DECEASED</b> (Type or Print) <i>WILLIAM JESSIE ARRING.</i>				<b>4. DATE OF DEATH</b> (Month) <i>7</i> (Day) <i>6</i> (Year) <i>1956</i>			
<b>5. SEX</b> <i>Male</i>		<b>6. COLOR OR RACE</b> <i>White</i>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>SINGLE</i>		<b>8. DATE OF BIRTH</b> <i>Feb. 2-1885</i>	
<b>9. AGE last birthday</b> <i>71</i> Yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Retired</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Retired</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Maryland</i>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>		<b>13. FATHER'S NAME</b> <i>WILLIAM ARRING</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>MATILDA J ARRING</i>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)	
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Sarah Burris, 106 Law St. Abd. Md</i>		<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>141X IMMEDIATE CAUSE (A)</b> <i>P.O. - H.S.C. V.D. (in sufficing)</i>				<b>18. MEDICAL CERTIFICATION</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <i>Ca tongue &amp; metastasis to neck</i>				<b>18. MEDICAL CERTIFICATION</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <i>(Radical Neck dissection)</i>				<b>18. MEDICAL CERTIFICATION</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <i>Ca tongue &amp; Metastasis to neck</i>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. AUTOPSY?</b>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from 6-15, 1956, to 7-6, 1956, that I last saw the deceased alive on 7-6, 1956, and that death occurred at 3:30 P.M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Wm. K. Brendle</i>				<b>DATE SIGNED</b> <i>7-7-56</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b> <i>7/9/56</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Church Hill Cemetery</i>		<b>LOCATION (City, town, or county) (State)</b> <i>Harre-de-Grace Md.</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Dr. L. Lewis</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Edgar J Lane</i>		<b>ADDRESS</b> <i>Church Hill</i>	
<b>DATE</b> <i>JUL 11 1956</i>							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07242

180

7278

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EDGEWOOD ROAD</u>		d. STREET ADDRESS <u>EDGEWOOD ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>Floyd Shipley Bezil</u>		4. DATE OF DEATH <u>July 15 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 25 1886</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ROBERT C. SHIPLEY</u>		14. MOTHER'S MAIDEN NAME <u>IDA L. CLEMENTS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>MRS. ALLEN C. SPENCER</u>		Address <u>EDGEWOOD, MD. EDGEWOOD RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive CV disease</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> (b) <u>  </u> (c) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/17/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell &amp; Sons Inc</u>		ADDRESS <u>1900 Eutaw Place</u>	
24a. REC'D BY REGISTRAR <u>Norma Moneys</u>		DATE <u>7/15/56</u>	
24b. REGISTRAR'S SIGNATURE		DATE	



JUL 23 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 782

7279

07243

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Convalescent Home</u>		d. STREET ADDRESS <u>Rural</u>	
3. NAME OF DECEASED (Type or print) <u>Vinton</u> First <u>Bernard</u> Middle <u>Blair</u> Last		4. DATE OF DEATH <u>July</u> Month <u>6</u> Day <u>1956</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 17, 1882</u> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus. Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bus.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Blair</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Burgan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-14-0675a</u>	
17. INFORMANT <u>Mrs. Clarence M. Harrison</u> Address <u>Baltimore, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GASTRIC HEMORRHAGE</u> <u>181X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF BLADDER ?</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 5, 1956</u> to <u>July 6, 1956</u> , that I last saw the deceased alive on <u>July 5, 1956</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford F. Hudson</u> M.D.		ADDRESS (Street, city or town, state) <u>Fork, Md.</u> DATE SIGNED <u>7/6/56</u>	
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 9, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fork Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Fork, Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Harcher, Benson Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>7. 9. 56</u>	24b. REGISTRAR'S SIGNATURE <u>Pravella Lowmool</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL CLASS		12. PLACE OF DEATH		13. DATE OF DEATH		14. TIME OF DEATH		15. CAUSE OF DEATH		16. MANNER OF DEATH		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF DECEASED	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07244  
Reg. Dist. No. 180

7280

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa, Rural</u>			c. LENGTH OF STAY IN 1b <u>instant</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Harry H.</u> Middle <u>B.</u> Last <u>Bowerman</u>				<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 4, 1937</u>	
9. AGE (In year last birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Co., Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George Bowerman</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Trout</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-32-6135</u>		17. INFORMANT <u>George Bowerman</u>		Address <u>White Marsh Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto-object type</u>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>7/28</u> 19 <u>56</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>White Marsh Road Joppa Harford Md</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 31, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Camp Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>White Marsh, Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas &amp; Son</u>				ADDRESS <u>Abingdon Md.</u>		24a. REC'D BY REGISTRAR DATE <u>July 31, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Norma S. Moore</u>				24c. REGISTRAR'S NAME <u>Norma S. Moore</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]	
AGE [Faint handwritten age]		RACE [Faint handwritten race]	
DATE OF DEATH [Faint handwritten date]		PLACE OF DEATH [Faint handwritten place]	
TIME OF DEATH [Faint handwritten time]		OCCASION OF DEATH [Faint handwritten occasion]	
CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]	
SIGNATURE OF EXAMINER [Faint handwritten signature]		OFFICE OF EXAMINER [Faint handwritten office]	
CITY [Faint handwritten city]		COUNTY [Faint handwritten county]	
STATE [Faint handwritten state]		ZIP CODE [Faint handwritten zip code]	

RECEIVED  
AUG 3 1956  
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ATC 1-5a 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07245

7266

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harre/Da Grace</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harre/Da Grace</u>		TOWN <u>24</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Emily Briney</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 18, 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Dec. 31, 1876</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Harford Co, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Edwin Crawford</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. Crawford Briney</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				18. MEDICAL CERTIFICATION <u>Harre/Da Grace, Md.</u>		<u>5 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerotic C.V. Disease</u>						<u>6 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>51</u> , to <u>July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 17</u> , 19 <u>56</u> , and that death occurred at <u>3:04</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Joseph H. Hake</u>				ADDRESS (Street, city, town, state) <u>Chardwell, Md.</u>		DATE SIGNED <u>July 18</u>	
23. BURIAL, CREMATION REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 20, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Run Cn.</u>		LOCATION (City, town, or county) (State) <u>Harford Co, Md.</u>	
24. REC'D BY REGISTRAR <u>July 19 '56</u>		REGISTRAR'S SIGNATURE <u>Bertha B. Knight</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Bailey</u>		ADDRESS <u>Wartlingford Md</u>	

RECEIVED

JUL 25 1956

BUREAU V. 1

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 15

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

1956

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 15

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7281 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07246  
Reg. Dist. No. 782

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>VA.</u> b. COUNTY <u>GRAYSON Co</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL BEL AIR MD</u>		c. LENGTH OF STAY IN 1b <u>7 DAYS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>VORNEY</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>ELMER</u> Middle <u>LEE</u> Last <u>ELLER</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>8</u> Year <u>19 56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 2 - 1900</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>VA. GRAYSON Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH ELLER</u>		14. MOTHER'S MAIDEN NAME <u>SARAH ORSBORN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>229-14-5116</u>	
17. INFORMANT <u>Blaine Baughness</u>		Address <u>Bel Air Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY OCCLUSION</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. S. Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. S. Fisher</u>		DATE SIGNED <u>7/8/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 11/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>VORNEY CEM. VA.</u>		22d. LOCATION (City, town, or county) (State) <u>VORNEY, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Foster Bel Air Md</u>		24a. REC'D BY REGISTRAR DATE <u>7-9-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Phyllis Lowndes</u>			



1945-1946

BUREAU V. S.

JUL 11 1956

RECEIVED

7267

## CERTIFICATE OF DEATH

Reg. Dist. No. 07247-135

1. PLACE OF DEATH o. COUNTY <i>Harford Maryland</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i> c. LENGTH OF STAY IN 1b <i>33 yrs.</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>none</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford, Md.</i> d. STREET ADDRESS <i>515 Chen</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mary</i> First <i>Strom</i> Middle <i>Chenoweth</i> Last 4. DATE OF DEATH <i>7/21/56</i> Month <i>7</i> Day <i>21</i> Year <i>19</i>				5. SEX <i>Female</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>Sept 18-1879</i> 9. AGE (In years last birthday) <i>76</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>none</i> 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>James L. Hughes</i> 14. MOTHER'S MAIDEN NAME <i>Clara Chenoweth</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> 16. SOCIAL SECURITY NO. <i>Unknown</i> 17. INFORMANT <i>Mrs C.C. Shays, 275 Chen St. Harford, Md.</i>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Bladder</i> <i>181X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>General Carcinomatosis</i> DUE TO (c) <i>Cachexia</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>4:24 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Charles J. Foley</i> M.D. <i>Harford, Md. 7/23/56</i> PHYSICIAN'S NAME (Type) <i>CHARLES J. FOLEY</i> <i>HAURDE DE GRACE - MD.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>7/23/56</i>		<i>Angel Hill</i>		<i>Harford Chen. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Daugherty &amp; Son, Harford Chen, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>July 23-56</i>		24b. REGISTRAR'S SIGNATURE <i>A.L. Lewis M.D.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

NAVY AND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

BUREAU V. S.

JUL 24 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7282

## CERTIFICATE OF DEATH

Reg. Dist. No. 07248

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Army Hospital Aberdeen Proving Ground</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>STUART</b> Middle <b>ADAMS</b> Last <b>HAMILTON</b>		4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 Apr 93</b>
9. AGE (In years last birthday) yrs. <b>63</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Colonel</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>	
11. BIRTHPLACE (State or foreign country) <b>New Hampshire</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harold H Hamilton</b>		14. MOTHER'S MAIDEN NAME <b>Winifred Adams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> <b>Yes</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Official US Army Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary insufficiency</b> <b>420.0</b> DUE TO <b>Hypertensive and arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary congestion</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>never attended</b> , to <b>never attended</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>not seen alive</b> , 19 <b>56</b> , and that death occurred at <b>2:35a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>US Army Hospital Aberdeen Proving Ground, Md.</b> DATE SIGNED <b>24 Jun 56</b>			
ACTUAL SIGNATURE <b>V. G. Coseriu, MD</b>		PHYSICIAN'S NAME (Type) <b>V. G. COSERIU</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>July 26th 1956</b>	<b>Arlington National Cem.</b>	<b>Arlington Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Sarruig</b>		24a. REC'D BY REGISTRAR DATE <b>July 26-56</b>	
ADDRESS <b>Aberdeen Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Nellie A. Perry</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

30 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07249**

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>PENND</b> b. COUNTY <b>York</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>322 B-1 A-1-2 MONTHS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delta</b> 75X-3	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Co. Convalescing Home</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Willard</b> First Middle Last		4. DATE OF DEATH <b>July 7, 1956</b> Month Day Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 26, 1889</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>METAL</b>	
11. BIRTHPLACE (State or foreign country) <b>HARFORD CO., MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JACOB HEAPS</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA BOUGHTER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-05-832</b>	
17. INFORMANT <b>MELVIN HEAPS, YORK, PA.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic CVD disease</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Gerald C Palmer</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Gerald C Palmer M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-19-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SLATE RIDGE</b>		22d. LOCATION (City, town, or county) (State) <b>DELTA, PA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Harkins</b>		24a. REC'D BY REGISTRAR <b>DATE 7-19-56</b>	
ADDRESS <b>Delta, Pa.</b>		24b. REGISTRAR'S SIGNATURE <b>Willa Louwood</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF ILLINOIS  
DEPARTMENT OF HEALTH—BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>July 23, 1956</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Chicago</i>		COUNTY <i>Cook</i>	
CAUSE OF DEATH <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>Engineer</i>		EDUCATION <i>High School</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		SIGNATURE OF MEDICAL EXAMINER <i>Dr. A. Jones</i>		SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>Mr. B. White</i>	
DATE OF SIGNATURE <i>July 23, 1956</i>		DATE OF SIGNATURE <i>July 23, 1956</i>		DATE OF SIGNATURE <i>July 23, 1956</i>		DATE OF SIGNATURE <i>July 23, 1956</i>	

BUREAU V. S.

JUL 23 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07250

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH COUNTY <u>Hartford</u> MARYLAND CITY OR TOWN <u>Harre-de-Grace</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Memorial Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Hartford</u> CITY OR TOWN <u>Joppa</u> STREET ADDRESS <u>Rural</u>			
3. NAME OF DECEASED (Type or Print) <u>George William Kroh</u>				4. DATE OF DEATH (Month) <u>7</u> (Day) <u>7</u> (Year) <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 16, 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
13. FATHER'S NAME <u>Curtis Kroh</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Leight</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS <u>Curtis Kroh (Son)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1 IMMEDIATE CAUSE (A) Arteriosclerotic Cardiovascular Disease</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 6th 1956</u> to <u>July 7th 1956</u> , that I last saw the deceased alive on <u>July 7th 1956</u> , and that death occurred at <u>7:20 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Edward Kroh</u> ADDRESS (Street, city, town, state) <u>211 N. Union Ave. Harre-de-Grace, Md.</u> DATE SIGNED <u>July 19, 1956</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 19, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mountain Christian</u>		LOCATION (City, town, or county) (State) <u>Joppa md</u>	
24. REC'D BY REGISTRAR DATE <u>11 1956</u>		REGISTRAR'S SIGNATURE <u>Dr. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Starcher</u>		ADDRESS <u>Benson md</u>	

# CERTIFICATE OF DEATH

MISSOURI STATE DEPARTMENT OF HEALTH - COLUMBIA, MO.

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX ☐ MALE ☐ FEMALE 4. AGE ☐ YEARS ☐ MONTHS ☐ DAYS

5. DATE OF BIRTH ☐ MONTH ☐ DAY ☐ YEAR

6. PLACE OF BIRTH ☐ STATE ☐ COUNTY ☐ CITY

7. OCCUPATION ☐ TRADE ☐ Vocation ☐ Profession

8. CAUSE OF DEATH ☐ Disease ☐ Injury ☐ Poison

9. MANNER OF DEATH ☐ Natural ☐ Accidental ☐ Suicidal

10. SIGNATURE OF DECEASED ☐ Signature ☐ Mark

11. SIGNATURE OF WITNESSES ☐ Signature ☐ Mark

12. SIGNATURE OF PHYSICIAN ☐ Signature ☐ Mark

13. SIGNATURE OF CORONER ☐ Signature ☐ Mark

14. SIGNATURE OF JURY ☐ Signature ☐ Mark

15. SIGNATURE OF JUDGE ☐ Signature ☐ Mark

16. SIGNATURE OF CLERK ☐ Signature ☐ Mark

17. SIGNATURE OF NOTARY ☐ Signature ☐ Mark

BUREAU V. 3

JUL 11 1956

RECEIVED

7270

## CERTIFICATE OF DEATH

Reg. Dist. No.

186-

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARRE DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARRE DE GRACE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>				d. STREET ADDRESS <u>428 MARKET ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>JULIA</u> Middle <u>VERONICA</u> Last <u>McKINNEY</u>				4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-25-1899</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas McKinnex</u>				14. MOTHER'S MAIDEN NAME <u>Emma ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MARGARET CRAIG</u>		Address <u>HARRE DE GRACE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation, Acute</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hrs.</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myelothetic anemia and thrombocytopenic purpura</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>7/23/56</u> , 19 <u>56</u> , to <u>7/30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 30th</u> , 19 <u>56</u> , and that death occurred at <u>10:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward C. Foo</u> M.D.				ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Harre de Grace, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Edward C. Foo, M.D.</u>				DATE SIGNED <u>July 30th 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Elin</u>		22d. LOCATION (City, town, or county) (State) <u>Harre de Grace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. M., Harre de Grace, Md.</u>				24a. REC'D BY REGISTRAR <u>Aug 4-56</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**BUREAU V. S.**

AUG 5 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The borium copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A5C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07252

7271

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Have de Grace</u>		LENGTH OF STAY (In this place) <u>3 1/2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Have de Grace</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>329 Wilson St</u>			
3. NAME OF DECEASED (Type or Print) <u>Bert Lee Powell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 26 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>FEB. 25 1878</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Chamberlain Powell</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Emerich</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>Mrs Mary Ethel Powell</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
541.0 IMMEDIATE CAUSE (A) <u>Severe Gastrointestinal Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 1/2 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Duodenal Ulcer</u>				<u>Unknown</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Cirrhosis of the liver</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>7/25/56</u>		19b. MAJOR FINDINGS OF OPERATION <u>Gastrointestinal Hemorrhage - Coag.</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>22 July 1956</u> , to <u>25 July 1956</u> , that I last saw the deceased alive on <u>26 July 1956</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>W. H. Sadowsky</u>				ADDRESS (Street, city, town, state) <u>600 S Union Av. Hildeburg 726/56</u>			
DATE <u>July 27-56</u>				DATE SIGNED <u>7/26/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JULY 28 56</u>		NAME OF CEMETERY OR CREMATORY <u>Angel Hill Cem.</u>		LOCATION (City, town, or county) (State) <u>HARFORD CO MD</u>	
24. REC'D BY REGISTRAR <u>July 27-56</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>Have de Grace MD.</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Form 10-1-54

2. ALICE HARRISON BROWN, JR. DECEASED

DATE OF DEATH

CAUSE

DATE

PLACE

AGE

SEX

1. NAME OF DECEASED

2. DATE

3. PLACE

4. AGE

5. SEX

6. OCCUPATION

7. CAUSE

8. DATE

9. PLACE

10. SEX

11. NAME OF DECEASED

12. DATE

13. PLACE

14. AGE

15. SEX

16. OCCUPATION

17. CAUSE

18. DATE

19. PLACE

20. SEX

21. NAME OF DECEASED

22. DATE

23. PLACE

24. AGE

25. SEX

26. OCCUPATION

27. CAUSE

28. DATE

29. PLACE

30. SEX

31. NAME OF DECEASED

32. DATE

33. PLACE

34. AGE

35. SEX

36. OCCUPATION

37. CAUSE

38. DATE

39. PLACE

40. SEX

41. NAME OF DECEASED

42. DATE

43. PLACE

44. AGE

45. SEX

46. OCCUPATION

47. CAUSE

48. DATE

49. PLACE

50. SEX

51. NAME OF DECEASED

52. DATE

53. PLACE

54. AGE

55. SEX

56. OCCUPATION

57. CAUSE

58. DATE

59. PLACE

60. SEX

61. NAME OF DECEASED

62. DATE

63. PLACE

64. AGE

65. SEX

66. OCCUPATION

67. CAUSE

68. DATE

69. PLACE

70. SEX

71. NAME OF DECEASED

72. DATE

73. PLACE

74. AGE

75. SEX

76. OCCUPATION

77. CAUSE

78. DATE

79. PLACE

80. SEX

81. NAME OF DECEASED

82. DATE

83. PLACE

84. AGE

85. SEX

86. OCCUPATION

87. CAUSE

88. DATE

89. PLACE

90. SEX

BUREAU V. 2

JUL 31 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7283

## CERTIFICATE OF DEATH

07253  
Reg. Dist. No. 782

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall RD</u>		c. LENGTH OF STAY IN 1b <u>36 y-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norrisville, White Hall R.D.</u>	
		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph Thomas Rogers</u>		4. DATE OF DEATH <u>July 31 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 24 1914</u>
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Emmorton Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elisha Johnson Rogers</u>		14. MOTHER'S MAIDEN NAME <u>Ann Proctor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs C.A. Rodgers</u>		Address <u>York Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Angina pectoris, arteriosclerosis</u> DUE TO (c) <u>Infirmitas of old age.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 30 1956</u> , to <u>July 31 1956</u> , that I last saw the deceased alive on <u>July 31 1956</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman H. Gemmill</u> M.D.		ADDRESS (Street, city or town, state) <u>Stewartstown, Pa.</u>	
PHYSICIAN'S NAME (Type) <u>Norman H. Gemmill</u>		DATE SIGNED <u>8/1/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 4-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Carmel</u>	22d. LOCATION (City, town, or county) (State) <u>Emmorton, Hartford Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin G. Kurtz</u>		ADDRESS <u>Janetville Md</u>	
24a. REC'D BY REGISTRAR <u>8-3-56</u>		24b. REGISTRAR'S SIGNATURE <u>Prue Ellen Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased: *James Thomas Jones*  
 Date of Death: *July 15, 1956*  
 Place of Death: *Home*  
 Cause of Death: *Heart Disease*  
 Age: *65*  
 Sex: *Male*  
 Race: *White*  
 Marital Status: *Married*  
 Occupation: *Teacher*  
 Signature of Physician: *[Signature]*  
 Signature of Registrar: *[Signature]*

BUREAU V. 1

AUG 5 1956

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## MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55

CERTIFICATE OF DEATH

1951

*[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]*

BUREAU V. S.

JUL 16 1956

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07255

## 7272 CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Cecil</i>	
CITY OR TOWN <i>Larude Grace</i>		LENGTH OF STAY (in this place)		CITY OR TOWN <i>N. East (Maryland)</i>		07X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Harford Memorial Hospital</i>				STREET ADDRESS <i>N. East Maryland</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<i>Fannis Sadowsky</i>				<i>July 2 1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>White</i>		<i>January 5, 1886</i>	<i>70</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>		<i>Home</i>		<i>Russia</i>		<i>U.S.A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Unknown</i>				<i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>No</i>				<i>Samuel Sadowsky North East, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4201- IMMEDIATE CAUSE (A)				<i>Coronary thrombosis with myocardial infarction</i>			
ANTECEDENT CAUSE(S) DUE TO				<i>Arteriosclerotic Cardiovascular disease</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<i>Diabetes Mellitus</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		<i>4 1/2 hrs.</i>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July 2nd, 1956</i> , to <i>July 2nd, 1956</i> , that I last saw the deceased alive on <i>July 2nd, 1956</i> , and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Edward Brown</i>				ADDRESS (Street, city, town, state) <i>211 N. Union Ave. Havre de Grace, Md.</i>		DATE SIGNED <i>July 2, 1956</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF GEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>7-5-1956</i>		<i>Mt. Lebanon Cemetery</i>		<i>Philadelphia, Pa</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>July 3, 1956</i>		<i>A. L. Lewis M.D.</i>		<i>Lee A. Patterson</i>		<i>San Perryville, Md.</i>	

# CERTIFICATE OF DEATH

Reg. No. 1-1-18

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF CONSTABLE

20. SIGNATURE OF JAILER

21. SIGNATURE OF PRISON WARDEN

22. SIGNATURE OF CHIEF OF POLICE

23. SIGNATURE OF DETECTIVE

24. SIGNATURE OF INSPECTOR

25. SIGNATURE OF SUPERVISOR

26. SIGNATURE OF AGENT

27. SIGNATURE OF CLERK

28. SIGNATURE OF SHERIFF

29. SIGNATURE OF DEPUTY SHERIFF

30. SIGNATURE OF CONSTABLE

31. SIGNATURE OF JAILER

32. SIGNATURE OF PRISON WARDEN

33. SIGNATURE OF CHIEF OF POLICE

34. SIGNATURE OF DETECTIVE

35. SIGNATURE OF INSPECTOR

36. SIGNATURE OF SUPERVISOR

37. SIGNATURE OF AGENT

38. SIGNATURE OF CLERK

39. SIGNATURE OF SHERIFF

40. SIGNATURE OF DEPUTY SHERIFF

41. SIGNATURE OF CONSTABLE

42. SIGNATURE OF JAILER

43. SIGNATURE OF PRISON WARDEN

BUREAU V. S.

JUL 5 1956

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7273 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07256

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford de Grace</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKS</u>	
3. NAME OF DECEASED (Type or print) <u>GROVER-Sam</u> First Middle Last		4. DATE OF DEATH <u>July</u> Month <u>30</u> Day <u>1956</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/19/1930</u>
9. AGE (In years last birthday) <u>24</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Belt &amp; Rubber Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Spicer</u>		14. MOTHER'S MARDEN NAME <u>Marie Boltitt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Estis Hask</u> Address <u>Rock Hills 6 Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury L. chest</u> 816 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture 2 Ribs</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto object type</u>	
20c. TIME OF INJURY Month, Day, Year <u>5</u> Hour <u>7/29</u> a. m. <u>1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hsk route 1</u>		20f. (City or town) <u>Kingville</u> (County) <u>Hartford</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7/30/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>8/1/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>North Oak Ridge</u>	22d. LOCATION (City, town, or county) (State) <u>Queen Co. N.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Conington Rm</u>		24a. REC'D BY REGISTRAR <u>G. L. Lewis M.D.</u>	
ADDRESS <u>Rock Hills 6 Md.</u>		24b. REGISTRAR'S SIGNATURE	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. Includes checkboxes for various conditions and a large area for the examiner's signature and notes.

BUREAU V. 1

JUG 1 1956

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# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

185-

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM?	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday)		IF UNDER 1 YEAR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gerald C Palmer - MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 6 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 12 FilmG200 7-23-56 et

07258

7275

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		LENGTH OF STAY (in this place) <u>7 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>		TOWN <u>07X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>R.D. #1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Richard</u>		(Middle) <u>T.</u>		(Last) <u>Western</u>		(Month) (Day) (Year) <u>7 14 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Dec 6 1867</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR Months   Days		IF UNDER 24 HRS. Hours   Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Unemployed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unemployed</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry Western</u>				14. MOTHER'S MAIDEN NAME <u>Edith Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Rising Sun R.D. Md. Richard Western (son)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
540.1 IMMEDIATE CAUSE (A) <u>G.I. (Lower) + DU Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-7</u> , 19 <u>56</u> , to <u>7-14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-14</u> , 19 <u>56</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Chas. K. Shunder</u>				ADDRESS (Street, city, town, state) <u>Harre de Grace</u>		DATE SIGNED <u>7-14-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 17 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		LOCATION (City, town, or county) (State) <u>Rising Sun R.D. Md</u>	
24. REC'D BY REGISTRAR <u>July 17-56</u>		REGISTRAR'S SIGNATURE <u>C. D. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Shurt</u>		ADDRESS <u>North East Md</u>	

# CERTIFICATE OF DEATH

Form 100-1-54

1. NAME OF DECEASED

2. SEX  
3. AGE

4. DATE OF BIRTH

5. RACE

6. SEX

7. AGE

8. DATE OF BIRTH

9. RACE

10. SEX

11. AGE

12. DATE OF BIRTH

13. RACE

14. SEX

15. RACE

16. SEX

17. AGE

18. DATE OF BIRTH

19. RACE

20. SEX

21. AGE

22. DATE OF BIRTH

23. RACE

24. SEX

25. RACE

26. SEX

27. AGE

28. DATE OF BIRTH

29. RACE

30. SEX

31. AGE

32. DATE OF BIRTH

33. RACE

34. SEX

35. RACE

36. SEX

37. AGE

38. DATE OF BIRTH

39. RACE

40. SEX

41. AGE

42. DATE OF BIRTH

43. RACE

44. SEX

45. RACE

46. SEX

47. AGE

48. DATE OF BIRTH

49. RACE

50. SEX

51. AGE

52. DATE OF BIRTH

53. RACE

54. SEX

55. RACE

56. SEX

57. AGE

58. DATE OF BIRTH

59. RACE

60. SEX

61. AGE

62. DATE OF BIRTH

63. RACE

64. SEX

65. RACE

66. SEX

67. AGE

68. DATE OF BIRTH

69. RACE

70. SEX

71. AGE

72. DATE OF BIRTH

73. RACE

74. SEX

BUREAU V. 8

JUL 18 1956

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1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be examined by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7276

## CERTIFICATE OF DEATH

07259  
Reg. Dist. No. 785-

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Harford</i> b. COUNTY <i>Maryland</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <i>Walter</i> Middle <i>Street</i> Last <i>Wilson</i>				4. DATE OF DEATH Month <i>July</i> Day <i>3</i> Year <i>1956</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 11 - 1888</i>			
9. AGE (In years last birthday) <i>68</i> yrs.		IF UNDER 1 YEAR Months <i>3</i> Days <i>3</i> Hours <i>3</i> Min.		IF UNDER 24 HRS. Months <i>3</i> Days <i>3</i> Hours <i>3</i> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <i>Transportation Executive</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Trucking Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>									
13. FATHER'S NAME <i>Wm. J. Wilson</i>				14. MOTHER'S MAIDEN NAME <i>Katherine Ely</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>265-05-3293</i>					
17. INFORMANT <i>Mrs. Carrie J. Wilson - Chesapeake Md.</i>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Primary</i> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <i>June 30, 1956</i> to <i>7-3, 1956</i> , that I last saw the deceased alive on <i>7-3, 1956</i> , and that death occurred at <i>12:45 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, State) <i>HAIRDE de GRACE Md</i> DATE SIGNED <i>7-3-56</i>									
ACTUAL SIGNATURE <i>[Signature]</i> M.D. <i>HAIRDE de GRACE Md</i>									
PHYSICIAN'S NAME (Type) <i>A. H. Lewis</i>				<i>HAIRDE de GRACE Md</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/6/1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Wm. J. Wilson Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Belt R. 17 Maryland</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John E. Garry</i>				ADDRESS <i>Chesapeake Md.</i>		24a. REC'D BY REGISTRAR DATE <i>July 6 - 56</i>			
				24b. REGISTRAR'S SIGNATURE <i>G. L. Lewis M.D.</i>					

CERTIFICATE OF DEATH

1956

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF DEATH <i>July 8, 1956</i></p>		<p>5. TIME OF DEATH <i>10:00 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>8. MANNER OF DEATH <i>Natural</i></p>		<p>9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i></p>	
<p>10. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>11. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>12. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>13. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>14. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>15. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>16. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>17. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>18. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>19. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>20. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>21. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>22. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>23. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>24. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>25. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>26. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>27. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>28. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>29. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>30. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>31. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>32. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>33. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>34. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>35. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>36. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>37. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>38. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>39. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>40. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>41. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>42. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>43. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>44. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>45. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>46. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>47. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>48. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>49. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>50. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>51. SIGNATURE OF WITNESS <i>John Doe</i></p>	
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<p>55. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>56. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>57. SIGNATURE OF WITNESS <i>John Doe</i></p>	
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<p>61. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>62. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>63. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>64. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>65. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>66. SIGNATURE OF WITNESS <i>John Doe</i></p>	
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<p>70. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>71. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>72. SIGNATURE OF WITNESS <i>John Doe</i></p>	
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<p>76. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>77. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>78. SIGNATURE OF WITNESS <i>John Doe</i></p>	
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<p>82. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>83. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>84. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>85. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>86. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>87. SIGNATURE OF WITNESS <i>John Doe</i></p>	
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<p>91. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>92. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>93. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>94. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>95. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>96. SIGNATURE OF WITNESS <i>John Doe</i></p>	
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<p>100. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>101. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>102. SIGNATURE OF WITNESS <i>John Doe</i></p>	

BUREAU V. 2

JUL 9 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07260

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

7285

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		STATE <u>Md</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harford</u>				TOWN <u>Harford</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Sarah a Bellman</u>				<u>July 6 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>July 12 1893</u>	<u>62</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Homemaker</u>		<u>None</u>		<u>Harford Co Md</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Ferguson</u>				<u>Luan Stephen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>No</u>		<u>Frank Bellman</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				15. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis</u>				<u>1 hr</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>r</u>				<u>13 yrs</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 25</u> , 19 <u>55</u> , to <u>July 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 6</u> , 19 <u>56</u> , and that death occurred at <u>7:00</u> M, from the causes end on the date stated above.							
SIGNATURE <u>F. Snodgrass</u>				ADDRESS (Street, city, town, state) <u>Narrington Md</u>		DATE SIGNED <u>7/7/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>July 9 1956</u>		<u>Harmon</u>		<u>Harford Co Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>July 7 '56</u>		<u>Bertha B. Knight</u>		<u>Asa Bailey</u>		<u>Parlinton, Md.</u>	

# CERTIFICATE OF DEATH

181

1. Name of deceased (Print or type)

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Usual residence

7. Cause of death

8. Date of death

9. Place of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of witness

15. Signature of witness

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BUREAU V. 1

RECEIVED

JUL 12 1956

July 12 1956 B. Knight

1. Name of deceased (Print or type)  
2. Sex  
3. Race  
4. Date of birth  
5. Place of birth  
6. Usual residence  
7. Cause of death  
8. Date of death  
9. Place of death  
10. Signature of physician  
11. Signature of registrar  
12. Signature of informant  
13. Signature of witness  
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